THE MED FORM

Name:_____Date Completed:_____
Preferred Pharmacy/Phone:_____
Address:_____
Phone Number:_____Birth Date:_____
Emergency Contact/Phone:_____

Allergies and Drugs to Avoid/Adverse Reactions:

_____
_____
_____

Current Medications:

List all medications you are taking, include over-the-counter (e.g., aspirin, antacids, vitamins and herbals).

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

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Reason for Taking:_____Directions:_____
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Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Current Medications: *(continued)*

Medication:______________________________ Dosage:______________
Reason for Taking:______________ Directions:______________________
Doctor:________________________ Date Started:__________________

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Reason for Taking:______________ Directions:______________________
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Reason for Taking:______________ Directions:______________________
Doctor:________________________ Date Started:__________________

Immunization Record:

(Include dates administered)

☐ Tetanus__________ ☐ Pneumonia Vaccine__________ ☐ Flu Vaccine__________
☐ Hepatitis B Vaccine__________ ☐ Other______________________________

Always keep this form with you.